SERFF Tracking Number:	*TRST-128343239*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00233*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*SL-0601 APP AR R04-12*		
Project Name/Number:	*2012 Stop Loss Application Filing/12.00233*		

Filing at a Glance

Company: Trustmark Life Insurance Company

Product Name: SL-0601 APP AR R04-12	SERFF Tr Num: TRST-128343239	State: Arkansas
TOI: H12 Health - Excess/Stop Loss	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H12.004 Self-Funded Health Plan	Co Tr Num: 12.00233	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Jeri Jacks	Disposition Date: 05/09/2012
	Date Submitted: 05/09/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 2012 Stop Loss Application Filing	Status of Filing in Domicile: Pending
Project Number: 12.00233	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Filed in Illinois; still under review.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 05/09/2012	
State Status Changed: 05/09/2012	Deemer Date:
Created By: Jeri Jacks	Submitted By: Lisa Sayerstad

Corresponding Filing Tracking Number:

Filing Description:

The above-outlined form is being submitted for review and approval for use in your state. This form is new and will not replace any existing form(s).

This application will be used with stop loss form SL-0601 AR R12-05, previously approved on 11/17/05 under our filing number 5.03647.

Because stop loss contracts are custom designed and contain variable options, we have submitted the application forms with bracketed text or numbers. The brackets indicate material that may change based on options elected by the

employers, marketing philosophy, or changes in state law. Variable material will always meet the minimum requirement of your state's laws.

The forms are in final printed format as issued from a laser printer. However, we use different computer publishing systems. Therefore, actual issued forms may have a different font style than the submitted forms. As a result, page breaks may occur at different lines and line wording may not match up exactly. The wording and its order, however, will remain identical. We do not anticipate re-filing for such font style variation.

If you have any questions or concerns about this filing, please contact me at (800) 666-6977, extension 34205 or at jjacks@trustmarkins.com.
State Narrative:

Company and Contact

Filing Contact Information

Jeri Jacks, Regulatory Advocacy Analyst	jjacks@trustmarkins.com
400 Field Drive	800-666-6977 [Phone] 34205 [Ext]
Lake Forest, IL 60045	847-615-3872 [FAX]

Filing Company Information

Trustmark Life Insurance Company	CoCode: 62863	State of Domicile: Illinois
400 Field Drive	Group Code: 276	Company Type:
Lake Forest, IL 60045	Group Name:	State ID Number:
(800) 666-6977 ext. [Phone]	FEIN Number: 36-3421358	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	The filing fee is $50 per form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Trustmark Life Insurance Company	$50.00	05/09/2012	59042994

SERFF Tracking Number:	*TRST-128343239*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
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TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*SL-0601 APP AR R04-12*		
Project Name/Number:	*2012 Stop Loss Application Filing/12.00233*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/09/2012	05/09/2012

SERFF Tracking Number:	*TRST-128343239*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00233*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*SL-0601 APP AR R04-12*		
Project Name/Number:	*2012 Stop Loss Application Filing/12.00233*		

Disposition

Disposition Date: 05/09/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*TRST-128343239*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00233*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*SL-0601 APP AR R04-12*		
Project Name/Number:	*2012 Stop Loss Application Filing/12.00233*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	Stop Loss Application	Approved-Closed	Yes

SERFF Tracking Number:	*TRST-128343239*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00233*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*SL-0601 APP AR R04-12*		
Project Name/Number:	*2012 Stop Loss Application Filing/12.00233*		

Form Schedule

Lead Form Number: SL-0601 APP AR R04-12

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/09/2012	SL-0601 APP AR R04-12	Application/ Enrollment Form	Stop Loss Application	Initial		44.000	SL-0601 APP AR R04-12 final 5-8-12.pdf

Underwritten by
Trustmark
LIFE INSURANCE COMPANY

TRUSTMARK LIFE INSURANCE COMPANY
Application for Stop Loss [and Ancillary] Insurance Coverage

Application is hereby made to Trustmark Life Insurance Company ("Company") for **[**Aggregate**] [**and**] [**Specific**]** Stop Loss Insurance. [Application may also include ancillary coverage as indicated on the proposal.] This Application must be accepted and approved by the Company prior to any Contract being in effect.

[Attach a copy of the proposal indicating the employer's plan selection(s) with this application.]

1. Full Legal name of **[**Employer/Policyholder/Applicant**]** _____

   _____

2. Key contact at **[**Employer/Policyholder**]**_____

[3.] **[**Company Plan Administrator (Name and Title)**]**_____

[Phone number:**]**_____ **[**Fax Number:**]**_____

[E-mail Address:**]**_____

[4.] Address _____

[5.] City, State, ZIP Code _____

_____

[6.] Subsidiary or affiliated companies (companies under common control through stock ownership, contract or otherwise) that are to be included. List legal names and addresses of such companies.

_____

_____

_____

[7.] **[Persons to be covered under the Stop Loss Contract:** Employees and dependents who meet the eligibility requirements as set forth under the **[**Employer/Policyholder**]**'s underlying Plan, except an employee or dependent who satisfies a description indicated in Item Numbers 1, through [7] of the Stop Loss Disclosure Statement, completed on behalf, and signed by a duly authorized officer of the **[**Employer/Policyholder**],** unless named on the Stop Loss Disclosure Statement and approved by Trustmark.**]**

[8.] Other locations. Include city, state and ZIP code.

_____

_____

[9.] **[**Name of UR Provider and/or PPO Organization(s).**]**

_____

_____

[10.]Nature of **[**Employer/Policyholder**]**'s Business **[**and Date Business Started.**]**

_____

☐ **[**Corporation**]** ☐ **[**Partnership**]** ☐ **[**Proprietorship**]** ☐ **[**Other**]** _____

[11.] Has the [Employer/Policyholder] ever voluntarily applied for relief in the Bankruptcy Court?
☐ Yes ☐ No If yes, explain

_____

_____

_____

[12.] Enter the full name of your Employee Benefit Plan

_____

[13.] **[**Name and address of **[**Employer/Policyholder**]**'s Third Party Administrator**]**

_____

_____

[14.] **[**Number of **full-time and part-time** employees:**]**_____

[15.] **[**Number of **full-time** employees:**]**_____

[16.] **[**Number of employes covered under or in election period of COBRA or state continuation:_____]

17.] **[**Number of employees in their **waiting period**:**]**_____

[NOTE: Any employees who in their waiting period and eligible for coverage within 60 days of the group's effective date must submit a completed Employee Eligibility Statement.]

[18.] **[**Eligible employees will be insured the first day of the month following **[**_____**]** days of continuous employment (waiting period).**]**

☐ Waive the waiting period for all employees during the initial enrollment

[19.] **[**Carve Out?**]** ☐ Yes ☐ No

If "yes", indicate the class to be covered _____

[20.] **[Prior Coverage:]**

[Is prior group medical coverage?**]**_____ ☐ fully insured ☐ self-funded

[Name of prior group medical carrier:**]**_____ **[**In effect since:**]**_____

[Name of prior group dental carrier:**]**_____ **[**In effect since:**]**_____

[Why are you leaving your current group carrier?**]**_____

[Premium renewal date with current group carrier?**]**_____

[Attach a copy of the most recent billing statement(s) from your prior carrier(s).]

[21.] **[**Retirees covered?**]** ☐ Yes ☐ No

[22.] **[Contribution:]**

[Employer Contribution: Employer may contribute toward the health coverage.]

[Employer contribution for employees:_____% Employer contribution for dependents_____%

[Please note: **[**Employer/Policyholder**]**'s Third Party Administrator must complete and submit a - Trustmark Stop Loss Administrator Application. Trustmark shall rely on such application in underwriting **[**Employer/Policyholder**]**'s application for Stop Loss Insurance coverage. Should subsequent information about the **[**Employer/Policyholder**]**'s Third Party Administrator's controls and processes become known, which, if known prior to underwriting this application was material because it would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of Coverage by providing notice to you.**]**

1. Proposed Effective Date _____
2. Total eligible employees _____ Estimated initial enrollment _____
3. Deposit premium $_____

GENERAL SCHEDULE OPTIONS

[A. Aggregate Stop Loss ☐ Yes ☐ No

Benefit Period: Eligible **[**Employer/Policyholder**]** Losses from Plan expense

Incurred from _____through _____, and

Paid from _____through _____.

Losses Incurred prior to the Effective Date will be limited to the amount as set forth in the Schedule of Stop Loss.

Coverages applying to Aggregate Stop Loss include (not included unless checked):

☐ **[**Medical**]** ☐ **[**Prescription Drug Card Program**]**

☐ **[**Dental Care**]** ☐ **[**Mail Order Prescription Drug Card Program**]**

☐ **[**Vision Care**]** ☐ **[**Weekly (Disability) Income**]**

☐ **[**Other **]**_____

[Aggregate Percentage Reimbursable (excess of Attachment Point) _____%**]**

[Maximum Aggregate Benefit, excess of Annual Aggregate Attachment Point, per Benefit Period

$_____**]**

[Maximum Employee Benefit Plan Losses per Covered Person per Benefit Period

$_____]

[Monthly Aggregate Accommodation ☐ Yes ☐ No]

[Aggregate Terminal Liability Protection ☐ Yes ☐ No]]

[B. Specific Stop Loss ☐ Yes ☐ No

Benefit Period: Eligible [Employer/Policyholder] Losses from Plan expenses

Incurred from _____through _____, and

Paid from _____through _____.

[Losses Incurred Prior to the Effective Date will be limited to the amount reimbursable as set forth in the Schedule of Stop Loss.]

[Eligible expenses for Specific Stop Loss include:

☒ [Medical] ☐ [Prescription Drug Card Program]

☐ [Dental Care] ☐ [Mail Order Prescription Drug Card Program]

☐ [Vision Care] ☐ [Weekly (Disability) Income]

☐ [Other]

[Specific Deductible (per person)$_____]

[Specific Percentage Reimbursable (excess of deductible) _____%]

[Lifetime Maximum Specific Benefit $_____
(per person in excess of Specific Deductible)]

RISK ASSUMPTIONS

Active Employees and Dependents:

The Company will rely on the data included in this application to assist in underwriting the [Employer/Policyholder] for Insurance.

[The Employee Eligibility Statement, Employee Application, Employee Enrollment Form or other similar form, which captures information regarding medical conditions and treatment of eligible persons, is made part of this application for insurance and shall be relied upon in determining rates and eligibility for coverage.

The Company has the right to revise the rates (retroactively or prospectively) for the Stop Loss Insurance Contract, or rescind or terminate the Stop Loss Insurance Contract if a person completes the Employee Eligibility Statement, Employee Application, Employee Enrollment Form or other similar form (collectively "Form") with false, incomplete or misleading information or fails to notify the Company of any changes to the answers to the medical information question in any Form resulting in a material misrepresentation affecting the assessment of the risk or the terms or conditions for coverage.]

[Note, that without Company review and consent in writing of each individual risk in the categories listed below, the participating [Employer/Policyholder]'s Losses will not be reimbursable under the Stop Loss Insurance Contract.

1. Eligible persons provided with health care during the last [twelve] months where the expenses for health care exceeded or are expected to exceed $ _____;
2. Eligible persons with health conditions which have the potential to exceed $ _____ in the next [twelve] months;

3. Eligible persons currently hospital or institution confined, or expected to be confined within **[**90 days**]** of the effective date;
4. Eligible persons who have had an organ or bone marrow transplant, or who have been evaluated for, or accepted into a transplant program;
5. Eligible persons who opt out of coverage under the **[**Employer/Policyholder**]**'s underlying Plan for any reason.

Please list all individuals who fall into any of the categories listed above and attach a completed Disclosure Statement listing all of these individuals.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please attach additional pages if needed.

Disabled and Continuing Employees and Dependents:

Are extended benefits available from the prior insurer for presently disabled eligible employees and/or their dependents? ☐ Yes ☐ No
Are any eligible employees or dependents presently disabled or confined in a hospital or similar facility? ☐ Yes ☐ No

Will any former employee or dependent be continuing coverage under the Plan in accordance with federal, state or local law on the effective date of this Contract? ☐ Yes ☐ No

If the answer is yes to any of the above three questions, please explain.

_____

_____

_____

_____

The **[**Employer/Policyholder**]**'s Losses from Plan benefits for any Employee who is not at his customary place of employment (or scheduled vacation) and any dependent, COBRA beneficiary, retiree and any Covered Person who is on Social Security disability continuance or any other leave of absence who is confined in a medical facility on the **[**Employer/Policyholder**]**'s Effective Date, will not be eligible for reimbursement under the Stop Loss Insurance Contract until:

- an employee returns to active, full-time work at his customary place of employment for at least one complete work day, performing all of the normal job duties required and expected of his position; or
- a dependent or continuation beneficiary is discharged from the medical facility of confinement.

If a Covered Person's health care coverage under the Plan is being continued in accordance with federal, state or local legislation on the **[**Employer/Policyholder**]**'s Stop Loss Insurance Contract effective date, his claims will not apply towards any Stop Loss Insurance deductibles or factors unless specifically agreed upon by the Company in writing.

The **[**Employer/Policyholder**]** hereby requests that the claims under the Plan for the following disabled persons and those individuals being continued in accordance with federal, state or local legislation be considered under the Stop Loss Contract. The **[**Employer/Policyholder**]** understands that the Company will evaluate the risk involved and may allow consideration of the following person's claims under the Stop Loss Insurance Contract by an adjustment in rates and or limitations placed upon such claims. The Company will provide the **[**Employer/Policyholder**]** specific written notification of its decision.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

The individuals listed above must be included on the Disclosure Statement.**]**

GENERAL CONDITIONS

It is understood and agreed as conditions precedent to the approval of this Application that:

- The **[**Employer/Policyholder**]** is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan;
- The Third Party Administrator retained by the **[**Employer/Policyholder**]** will be considered the **[**Employer/Policyholder**]**'s Agent and not the Company's Agent;
- All documentation**[** including the Employee Eligibility Statement**]** requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within **[**thirty (30) days**]** of the Effective Date;
- The Company will evaluate the **[**Employer/Policyholder**]**'s risk, and may require adjustments of rates, factors and or special limitations to accommodate for abnormal risks;
- Premiums are not considered paid until the premium check is received by the Company and at the rates set forth in the Schedule of Stop Loss.

[If the **[**Employer/Policyholder**]** has more than one business location, a representative of the **[**Employer/Policyholder**]** at each location has reviewed and completed the Risk Assumption section of this application and appropriate responses on the Disclosure Statement.**]**

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

In making this application, the **[**Employer/Policyholder**]** represents that such information accurately reflects the true facts and that the undersigned has authority to bind the **[**Employer/Policyholder**]** to the proposed Contract. Accordingly, this request will be a part of the Contract if accepted by the Company.

Any person who knowingly presents a false or fraudulent claim for payment of loss or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ this ___ day of _____, **[**2007**]**

Employer/Policyholder_____
Type or Print

Authorized Office/Partner_____

Title_____

Tax ID #_____

Witness:_____

Writing agent or broker of [Employer/Policyholder]_____
Please Print

Writing agent or broker of [Employer/Policyholder]_____
Signature

Social Security No. Or Tax ID_____

Address _____
_____
_____

Where is the Contract and other correspondence to be mailed? _____
_____
_____

SERFF Tracking Number:	*TRST-128343239*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
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TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*SL-0601 APP AR R04-12*		
Project Name/Number:	*2012 Stop Loss Application Filing/12.00233*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	05/09/2012

Comments:

This is an application filing for a policy that has already been approved. See description under General Information tab.

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/09/2012

Comments:

Attachment:

AR Flesch.pdf

Trustmark
Insurance Companies

Law Department

Phone 847.615.1500
Fax 847.615.3872

This is to certify the forms shown below comply with the requirements of Arkansas Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act and have achieved a Flesch reading ease score as follows:

Form	Flesch Score
SL-0601 APP AR R04-12	44

Sandra Przybyszewski

Digitally signed by Sandra Przybyszewski
DN: cn=Sandra Przybyszewski, c=US
Date: 2012.05.08 13:17:54 -05'00'

Sandra Przybyszewski
Vice President

ARKANSAS